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Cutting Through Pennsylvania's Medical Informed Consent Statute: A Reasonable Interpretation Abolishing the Surgical Requirement

I. Introduction

Pennsylvania courts have long protected patients' autonomy in making decisions regarding their health care.[1] Emboldened in this principle is a physician's duty to obtain a patient's informed consent before treatment.[2] Traditionally, the physician's duty to inform a patient of the risks and alternatives of treatment has been limited to surgical procedures.[3] Consequently, under Pennsylvania's common law doctrine, there has been no duty to obtain consent for non-invasive medical procedures.[4]

On November 26, 1996, in an effort to control the escalating costs of malpractice insurance,[5] Pennsylvania's General Assembly passed legislation expanding and codifying the common law doctrine of informed consent.[6] In December of 1997, the Pennsylvania Supreme Court steadfastly refused to expand the common law doctrine to include non-surgical procedures.[7] In dicta, the court acknowledged the legislature's expansion of the informed consent doctrine; the court, however, rebuffed the statute as a means to include previously excluded non-surgical procedures.[8]

This Comment analyzes Pennsylvania's informed consent statute and offers a reasonable interpretation supportive of

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1. *See, e.g.*, Moscicki v. Shor, 163 A. 341 (Pa. Super. Ct. 1932).
2. *See id.*
3. *See* Morgan v. MacPhail, 704 A.2d 617, 619 (Pa. 1997) ("It has long been the law in Pennsylvania that a physician must obtain informed consent from a patient before performing a surgical or operative procedure.").
4. *See id.*
5. *See* Christopher Guadagnino, Ph.D., *CAT Fund Fight Brings Historic Tort Reform* (visited Oct. 26, 1998) <http://www.physiciansnews.com/cover/1296.html>.
6. *See* Informed Consent, PA. STAT. ANN. tit. 40, § 1301.811-A (West Supp. 1998).
7. *See Morgan*, 704 A.2d at 620.
8. *See id.* at 620 n.6.

expanding physicians' duty to obtain informed consent for non-surgical procedures, thereby abolishing the traditional surgical requirement. Part II of this Comment examines the background of Pennsylvania's informed consent common law and statute. Within this Part, Section A reviews the development of the common law surgical requirement. Section B describes the codification of the informed consent doctrine and circumstances surrounding enactment of the statute. Section C summarizes the facts and reasoning of *Morgan v. MacPhail*[9] in which the Pennsylvania Supreme Court defines the informed consent surgery requirement. This Section also assesses the court's narrow interpretation of the statute, thereby limiting the future application of the statute to enumerated procedures and services.

Part III of this Comment analyzes the legislative intent underlying the informed consent statute. Within this Part, Section A discusses the competing theories of negligence and battery under which the Statute may be applied. In addition, this Section identifies the ambiguity and differing interpretations of the statute. Section B describes the rules of statutory construction that courts must use to resolve the ambiguity surrounding the statute. Section C examines the statute's objective of medical malpractice cost containment. Section D compares the informed consent statute with other statutes and regulations protecting similar persons. Section E posits a liberal application of the statute to effectuate the legislative intent and to serve the public interest. Section F introduces the principles of duty analysis to determine the extent of physicians' duty under an expanded definition of informed consent. Finally, Part IV of this Comment, concludes that the informed consent statute can be reasonably interpreted to abolish the surgical requirement.

II. Background

A. History of Pennsylvania's Informed Consent Surgical Requirement

In 1932, *Moscicki v. Shor*[10] set the cornerstone of Pennsylvania's surgical requirement under the medical informed consent doctrine. In *Moscicki*, a dentist informed his patient that all of her

9. 704 A.2d 617 (Pa. 1997).
10. *See* 163 A. 341 (Pa. Super. Ct. 1932).

teeth would need to be removed before receiving a full set of dentures.[11] The patient consented to have all of her teeth in the lower jaw, as well as three abscessed upper teeth, pulled.[12] Rather than removing only the teeth he received consent to pull, the dentist extracted all of the patient's teeth.[13] In its opinion, the court enunciated the general rule that, in non-emergent circumstances, a surgeon must obtain a competent patient's informed consent prior to a *surgery*.[14]

Under these circumstances, Pennsylvania's doctrine of informed consent was formulated: "[A]ny extension of the operation by the physician without the consent of the patient or someone authorized to speak for him constituted a battery or trespass . . . ."[15] Unlike a medical negligence action,[16] informed consent is grounded in the theory that a physician's failure to obtain a patient's informed consent constitutes a technical battery.[17] Traditionally, battery has been recognized as an individual's right to be free of unwanted and harmful bodily contact.[18] Without the patient's informed consent, the physician is liable for any injuries resulting from the touching, regardless of whether the treatment was negligently performed.[19]

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11. *See id.*

12. *See id.*

13. *See id.*

14. *See id.* (emphasis added); *accord* Dicenzo v. Berg, 16 A.2d 15 (Pa. 1940); Smith v. Yohe, 194 A.2d 167 (Pa. 1963); Gray v. Grunnagle, 223 A.2d 663 (Pa. 1966).

15. *See* Gray v. Grunnagle, 223 A.2d 663, 667 (Pa. 1966).

16. "In medical malpractice litigation, negligence is the predominant theory of liability." BLACK'S LAW DICTIONARY 662 (6th ed. abr. 1990). Medical negligence requires that the plaintiff prove that her harm is a result of the physician's failure to possess or to use the required skill and/or knowledge that a reasonable prudent provider would exercise under similar circumstances. *See id.*; *see also Gray*, 223 A.2d at 668. The terms "medical malpractice," "medical negligence," and "battery" can be a source of confusion and are often interchanged. Compounding this confusion is the General Assembly's use of "medical negligence" in the Declaration of Policy of the Medical Malpractice provisions of the Health Care Services Malpractice Act, under which the informed consent statute is located. *See* PA. STAT. ANN. tit. 40, § 1301.801-A (West Supp. 1998). This matter is addressed in the Analysis section of this Comment. For purposes of consistency, "medical malpractice" encompasses both "medical negligence" and "battery."

17. *See Moscicki*, 163 A. at 342 ("An operation without the consent of the patient . . . constitutes a technical assault."); *accord Smith*, 194 A.2d at 174; *Gray*, 223 A.2d at 669.

18. *See* Herr v. Booten, 580 A.2d 1115, 1117 (Pa. Super. Ct. 1990) (citing RESTATEMENT (SECOND) OF TORTS § 18 cmt. c (1965))

19. *See* Cooper v. Cohen, 286 A.2d 647, 649 (Pa. Super. Ct. 1971). *See also* Matthies v. Mastromonaco, No. A-9 Sept. Term 1998, 1999 WL 462173 at *5 (N.J. July 8, 1999) ("The essential difference in analyzing informed consent claims under negligence, rather than

In 1966, *Gray v. Grunnagle*[20] completed the foundation of the Commonwealth's surgical requirement.[21] Borrowing from the Supreme Court of North Carolina, the Pennsylvania Supreme Court traced the development of the battery theory from a time when major surgery was performed in the patient's home.[22] During these times, the limitations of diagnostic medicine prevented the surgeon from making an accurate diagnosis prior to the incision.[23] It was not until the patient was anesthetized and undergoing surgery could the surgeon determine what the necessary procedure might be.[24] Because the surgery often took place at the patient's home with the patient rendered unconscious by the shock of the surgery, immediate family members were usually at hand to consent to expanding the scope of the procedure.[25]

Framing the physician-patient relationship as contractual in nature,[26] the *Gray* court held that "for there to be valid consent it must be clear that both parties understand the nature of the undertaking and what the possible as well as the expected results might be."[27] Since the patient bears the expense, pain, and suffering accruing to an adverse outcome, the patient has a right to know of the inherent risks of the proposed treatment.[28] Under

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battery principles, is that the analysis focuses not on an unauthorized touching or invasion of the patient's body, but on the physician's deviation from a standard of care.").

20. 223 A.2d 663 (Pa. 1966).

21. *See id.* at 668-69; *accord* Sinclair v. Block, 633 A.2d 1137 (Pa. 1993); Morgan v. MacPhail, 704 A.2d 617 (Pa. 1997). In *Gray*, the Pennsylvania Supreme Court reversed the lower court's grant of *judgement non obstante veredicto* following a jury verdict that the surgeon exceeded the scope of the patient's consent to exploratory surgery when the surgeon proceeded to excise material surrounding the patient's spinal cord. *See Gray*, 223 A.2d at 665-667. Prior to the surgery, the patient suffered from muscular atrophy of the leg which would sometimes cause his left foot to invert. *See id.* at 665. The surgeon failed to advise the patient that the procedure carried a 15-20% risk of paralysis. *See id.* at 673. Following the surgery, the patient was paralyzed and unable to walk. *See id.* at 666.

22. *See Gray*, 223 A.2d at 666-67 (quoting Chief Justice Barnhill in Kennedy v. Parrott, 90 S.E.2d 754 (N.C. 1956)).

23. *See id.* at 667.

24. *See id.*

25. *See id.*

26. *See id.* at 669 (quoting Robert E. Powell, *Consent to Operation*, 21 MD. L. REV. 189, 191 (1961)).

27. *Gray*, 223 A.2d at 674. *See* Cooper v. Roberts, 286 A.2d 647, 650 (Pa. Super. Ct. 1971) (quoting Berkley v. Anderson, 82 Cal. Rptr. 67 (1970) ("[A] physician's duty to disclose is . . . imposed by law which governs his conduct in the same manner as others in a similar fiduciary relationship.").

28. *See Gray*, 223 A.2d at 674. *See also* PA. STAT. ANN. tit. 40, § 1301.811-A(b) (West Supp. 1998) (essentially codifying the elements of informed consent in *Gouse v. Cassel*, 615

this doctrine, a competent patient is granted the right to medical self-determination.[29]

In 1971, the Pennsylvania Superior Court, in *Cooper v. Cohen*,[30] interpreted *Gray* to imply that the primary interest of Pennsylvania courts is to inform fully patients of all material facts so they can make an intelligent choice of their medical treatment.[31] Expanding the informed consent doctrine, the court held that "the same duty of disclosure obtains [sic] whether or not the treatment can be technically termed operative or surgical."[32]

Twenty-two years after the Superior Court's decision in *Cooper*, the Pennsylvania Supreme Court explicitly stated that surgery is a requirement under the informed consent doctrine.[33] In 1993, in *Sinclair v. Block*,[34] a mother was experiencing complications during natural childbirth.[35] Using a pair of forceps, a physician attempted to facilitate a natural delivery by correcting the baby's position within the mother's birth canal.[36] Failing this procedure, the baby was subsequently delivered by Caesarian section.[37] Following the birth, the baby appeared to have some swelling on her scalp and faint marks on her forehead and face, allegedly caused by the forceps.[38] It was later determined that the newborn suffered from a skull fracture and seizures.[39]

The family maintained that the physician's use of the forceps constituted an operative procedure and required the mother's

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A.2d 331, 333 (Pa. 1992)). Informed consent is achieved when a patient receives a description of a medical procedure and information concerning the risks and alternatives that a reasonably prudent person would require to make an informed decision before the procedure. *See* PA. STAT. ANN. tit. 40, § 1301.811-A(b).

29. *See* Sinclair v. Block, 633 A.2d 1137, 1140 (Pa. 1993).

30. 286 A.2d 647 (Pa. Super. Ct. 1971).

31. *See id.* at 650. In *Cooper*, the patient signed a "blanket consent form" permitting physicians to perform a non-invasive, gastroscopic examination of the patient by guiding a semi-rigid fiberscope through the patient's mouth to photograph areas of her stomach. *See id.* at 648. The scope subsequently punctured the patient's stomach. *See id.*

32. *Id.* at 649 n.2. The court found the gastroscopic procedure closely related to surgery when it involved anesthesia and transport to a special examination room. *See id.*

33. *See* Sinclair v. Block, 633 A.2d 1137, 1139-40 (Pa. 1993) (requiring a "surgical or operative procedure.").

34. *Id.*

35. *See id.* at 1138.

36. *See id.*

37. *See id.*

38. *See Sinclair*, 633 A.2d at 1138.

39. *See id.*

informed consent.[40] The court, however, held that the instrument was merely an extension of the physician's hands used in the natural delivery process.[41] Re-iterating the surgical requirement for obtaining informed consent, the court stated that the doctrine presupposes that the patient has a choice to make.[42] "Thus, because labor is inevitable and there is no choice to make, the informed consent doctrine does not apply to the natural delivery process."[43]

B. *Pennsylvania's Informed Consent Statute: Codifying the Common Law Doctrine and Expanding Physicians' Duty*

On November 26, 1996, Pennsylvania's General Assembly unanimously amended the Health Care Services Malpractice Act ("Act").[44] The Act substantially codified the state's common law doctrine of informed consent[45] under which physicians had a duty to obtain a patient's informed consent for surgery and the related administration of anesthesia,[46] insertion of a surgical device or appliance,[47] and use of experimental devices and medications.[48]

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40. *See id.* at 1140.

41. *See id.* Therefore, the physician was not required to obtain the patient's specific consent to use the forceps, but rather the general consent to childbirth was sufficient to cover its use. *See id.* at 1141.

42. *See id.* at 1140.

43. *See Sinclair*, 633 A.2d at 1141; *cf.* Gordon v. Bakare, 118 Dauph. 253 (Pa. Com. Pl. 1998) (permitting a mother's informed consent cause of action to remain when her physician failed to explore the benefits and problems of a surgical alternative to the natural delivery process). The Common Pleas court limited the *Sinclair* holding to whether the use of forceps during delivery was a surgical procedure and not whether informed consent was relevant to delivery of a baby. *See id.* at 256.

44. *See* PA. STAT. ANN. tit. 40, §§ 1301.101-.1006 (West 1992 & Supp. 1998).

45. Prior to amendment, the Health Care Services Malpractice Act was silent as to which procedures or treatments required a physician to obtain a patient's informed consent. *See* PA. STAT. ANN. tit. 40, § 1301.103 (West 1991). The 1996 Act rewrote the definition of informed consent and incorporated by reference PA. STAT. ANN. tit. 40, § 1301.811-A, enumerating those procedures requiring informed consent. *See* PA. STAT. ANN. tit. 40, § 1301.103 (West Supp. 1998).

46. *See* Gray v. Grunnagle, 223 A.2d 663 (Pa. 1966) (holding that informed consent is required for surgery); Sauro v. Shea, 390 A.2d 259, 263 (Pa. Super. Ct. 1978) (imposing a duty to inform patients of risks and consequences of surgery and anesthesia).

47. *See* Stover v. Association of Thoracic and Cardiovascular Surgeons, 635 A.2d 1047 (Pa. Super. Ct. 1993) (holding that implantation of a mechanical heart valve required consent); Green v. Dolsky, 685 A.2d 110 (Pa. 1996) (recognizing that informed consent under state law may be superseded by the Food and Drug Administration's Medical Device Act requirements to inform patients).

48. *See* 21 U.S.C. § 360j(g)(3)(D) (1998) (providing a federal requirement of informed consent for the use of experimental devices on humans); 21 U.S.C. § 355(i)(4) (1998)

In addition, the Legislature expanded this judicially created doctrine to include medical procedures previously excluded under the common law of informed consent.[49] With codification, physicians' informed consent duties are augmented to include radiation, chemotherapy, and non-surgical related blood transfusions.[50]

The Act was the result of a reform effort to address an impending financial meltdown with the state's Medical Professional Liability Catastrophe Loss (CAT) Fund.[51] In 1975, the state established the CAT Fund in response to a medical malpractice insurance crisis.[52] Factors, including the relatively small size of Pennsylvania's insurance carriers and the length of time between premium collection and claim payment, created a financial uncertainty for insurers.[53] At the time, insurers sought up to 200 percent premium increases to reduce the risk that a string of very large verdicts may render companies insolvent.[54] The purpose of the CAT Fund ("Fund") was to provide affordable malpractice insurance for all medical providers[55] by removing the actuarial uncertainty of future claims and developing a "pay-as-you-go" system.[56] Under this system, physicians are required to pay the

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(providing a federal requirement of informed consent for the use of experimental medications).

49. *See* Dible v. Vagley, 612 A.2d 493, 496 (Pa. Super. Ct. 1992) (holding that there is no informed consent requirement for radiation treatment). *But see id.* at 500 (Hester, J., concurring/dissenting) (finding an exception to extend the informed consent doctrine to include radiation treatment). *See also* Jones v. Philadelphia College of Osteopathic Med., 813 F. Supp. 1125, 1129-30 (E.D. Pa. 1993) (explaining that a physician cannot fully inform a patient of all material risks without also informing of risks involved in potential blood transfusion).

50. *See* 40 PA. CONS. STAT. ANN. § 1301.811-A(a)(2)-(3) (West Supp. 1998).

51. *See* Guadagnino, *supra* note 5.

52. *See* Gill Taylor-Tyree, M.D., *CAT Fund Fact Sheet* (visited Oct. 26, 1998) <http://www.xray.hmc.psu.edu/PRS/nov96_CATfund.html>. In the early 1970's, New York faced similar circumstances where malpractice insurance premiums "doubled and were threatening to triple." *See* Lakowitz v. CIBA Vision Corp., 632 N.Y.S.2d 845 (N.Y. App. Div. 1995). On July 1, 1975, there was a danger that malpractice insurance would not be available in New York. *See id.* In reaction, the legislature enacted the New York Public Health Law § 2805-d (McKinney 1993) "placing novel restrictions on the doctrine of informed consent." *See id.*

53. *See id.*

54. *See id.* One insurance company actually fulfilled its threat to leave the Pennsylvania market. *See id.*

55. *See* Jeff McGaw, *Malpractice Reform Bill OK'd: Lawmakers Target Frivolous Lawsuits, Cost of Insurance*, HARRISBURG PATRIOT, Nov. 21, 1996, at B5.

56. *See* Taylor-Tyree, *supra* note 52.

Fund a surcharge based on a percentage of the insurer's premium.[57] In recent years, however, medical malpractice insurers have deeply discounted premiums.[58] Given the declining basis for calculating surcharges and significantly under-funded liabilities,[59] the CAT Fund proposed a surcharge increase of 254 percent for 1997.[60]

Incensed by the proposed increase,[61] over 2,000 supporters marched through Harrisburg, Pennsylvania seeking medical malpractice tort reform.[62] The Legislature, concerned with the possible exodus of physicians due to the cost of malpractice insurance, sought to protect the interests of Pennsylvania's citizens, communities, and professions.[63] Following two weeks of intense negotiations between the Pennsylvania Medical Society (PMS) and the Pennsylvania Trial Lawyers Association (PTLA),[64] the Health Care Services Malpractice Act was unanimously passed by the State House and Senate and signed by Governor Ridge.[65] Advocates of the legislation maintain that the Act was a "victory for physicians . . . struggling with the burden of an unfairly titled medical liability system."[66]

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57. *See id.*

58. *See* McGaw, *supra* note 55.

59. *See id.* In 1996, the CAT Fund had an estimated $1.9 billion in unfunded liabilities. *See* Guadagnino, *supra* note 5.

60. *See* McGaw, *supra* note 55 (noting that 1995 and 1996 surcharges were 102 percent and 164 percent of premiums, respectively).

61. *See* Guadagnino, *supra* note 5.

62. *See* Victor F. Greco, M.D. (President of the Pennsylvania Medical Society), *My Opinion of Act 135* (visited Oct. 26, 1998) <http://www.physiciansnews.com/discussion-/greco.html>.

63. *See* S. 180-67, 2nd Legis. Sess. 2645 (Pa. 1996) (remarks of Senator Jubelirer). Recognizing its primary obligation to ensure that patients "do not pay the price of solving these problems," the General Assembly considered legislation to address both the CAT Fund crisis and factors that contribute to increased malpractice expenses. *See id.* at 2647 (remarks of Senator Fisher).

64. *See* McGaw, *supra* note 55.

65. *See* Guadagnino, *supra* note 5.

66. Greco, *supra* note 62; *see also* McGaw, *supra* note 55 (quoting Senator Michael O'Pake: "Neither side is entirely satisfied, and what that probably means is that the average person in Pennsylvania will be the winner today.").

C. Morgan v. MacPhail: *The Pennsylvania Supreme Court's Informed Consent Surgical Definition*

On December 24, 1997, in *Morgan v. MacPhail*,[67] the Pennsylvania Supreme Court held that the surgical requirement will continue to remain a bar to patient remedies under the common law doctrine of informed consent.[68] In October of 1988, Barbara Morgan fell and fractured two of her ribs.[69] Suffering from continued pain two months after the fall, Mrs. Morgan sought treatment from Dr. John MacPhail.[70] Without her informed consent, Dr. MacPhail performed an intercostal nerve block, a procedure whereby a local anesthetic is injected into the area around the ribs,[71] on Mrs. Morgan to relieve her pain.[72] Following the procedure, Mrs. Morgan began to experience weakness and shortness of breath.[73] After telephoning Dr. MacPhail, Mrs. Morgan then went to a hospital emergency department where she was diagnosed with a right pneumothorax.[74]

A pneumothorax is a collection of air in the chest cavity outside of the lungs caused by a puncture to the chest wall or lung.[75] Air trapped in the chest cavity can expand and build up enough pressure to not only collapse the lung on the injured side, but also eventually collapse the lung on the uninjured side and compress the heart.[76] This life threatening condition requires immediate medical attention.[77] In Mrs. Morgan's case, her pneumothorax resulted from the nerve block procedure administered by Dr. MacPhail.[78]

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67. 704 A.2d 617 (Pa. 1997).

68. *See id.* at 620.

69. *See id.* at 618.

70. *See* Morgan v. McPhail, 672 A.2d 1359, 1360 (Pa. Super. Ct. 1996). The spelling of Appellee's name differs slightly between the captions of the Pennsylvania Superior and Supreme Court opinions. *Compare id. with Morgan*, 704 A.2d 617 (spelling the Appellee's name as "MacPhail"). To maintain consistency with the Pennsylvania Supreme Court's opinion, the Appellee's name will hereinafter be referred to as "MacPhail" within the text.

71. *See Morgan*, 704 A.2d at 618 n.1.

72. *See Morgan*, 672 A.2d at 1360.

73. *See id.*

74. *See Morgan*, 704 A.2d at 618.

75. *See* HARVEY D. GRANT ET AL., BRADY EMERGENCY CARE 722 (5th ed. 1990).

76. *See* BRENT Q. HAFEN ET AL., BRADY PRE-HOSPITAL EMERGENCY CARE 655-56 (5th ed. 1996).

77. *See id.*

78. *See Morgan*, 704 A.2d at 618.

Mrs. Morgan subsequently sued Dr. MacPhail alleging that he failed to obtain her informed consent prior to performing the procedure.[79] Because Mrs. Morgan's cause of action arose before enactment of the informed consent statute, the court was obligated to decide her case under the common law doctrine.[80] Sustaining Dr. MacPhail's preliminary objection, the Common Pleas court found that Mrs. Morgan's informed consent was necessary only for surgical or operative procedures.[81] Upon appeal, the Superior Court struggled to find the logic of the surgical/non-surgical distinction under the informed consent doctrine.[82] "[I]t would be less than candid if [the court] failed to 'admit to a degree of artificiality in creating a distinction which limits the touching required for actionable informed consent to be the surgical cut.' "[83] Affirming the lower court's decision,[84] the Superior Court stated that "our reservations regarding the injustice of this rule do not free us from the constraints imposed upon us as an intermediate appellate court."[85]

In 1997, the Pennsylvania Supreme Court considered Mrs. Morgan's appeal.[86] Noting that neither the courts nor the legislature has defined surgical or operative procedures, the Supreme Court concluded that surgical or operative procedures involve "an excision or incision or the use of surgical instruments."[87] The court stated that it is the invasive nature of surgery that gives rise

79. *See Morgan,* 672 A.2d at 1360.

80. *See Morgan*, 704 A.2d at 620 n.6.

81. *See Morgan,* 672 A.2d at 1360.

82. *See id.* at 1364.

83. *Id.* (quoting Stover v. Association of Thoracic and Cardiovascular Surgeons, 635 A.2d 1047, 1054 n.6 (Pa. Super. Ct. 1993)).

84. *See id.*

85. *Id.* at 1363. The court stated that its two primary functions are to apply the existing law and "stimulate revision in the law by the highest court where reform or clarification is necessary."

86. *See Morgan*, 704 A.2d at 618 (consolidating the appeal of *Morgan v. MacPhail,* 672 A.2d 1359 (Pa. Super. Ct. 1996) and *Walker v. Rose*, No. 4044 (Pa. Super. Ct. 1996)).

87. *Id.* at 619 (citing TABER'S CYCLOPEDIC MEDICAL DICTIONARY 1256 (16th ed. 1989) to provide the definition of "operate" and BLACK'S LAW DICTIONARY 1092, 1442 (6th ed. 1990) to provide the definition of "operation" and "surgery", respectively); *cf.* BLACK'S LAW DICTIONARY 1442 (6th ed. 1990) ("There can never be a complete separation between the practice of medicine and surgery; the principles of both are the same throughout, and no one is qualified to practice either who does not properly understand the fundamental principles of both.").

to the need to obtain a patient's consent.[88] Furthermore, the court reasoned that since a surgery patient is "typically unconscious and unable to object," surgery without the consent of the patient is a technical battery.[89] Because the procedure received by Mrs. Morgan did not "rise to the same level of bodily invasion as surgery," the court affirmed the decision of the Superior Court and maintained the surgery requirement for obtaining informed consent.[90]

In *dicta*, the Pennsylvania Supreme Court recognized the recent codification and expansion of the informed consent doctrine.[91] Although not applicable in the instant case, the court took a decidedly narrow interpretation of the statute by stating that it could find no reason to expand judicially the doctrine of informed consent only to have it overturned by the statute.[92] While the majority in *Morgan* acknowledged the expanded duty of physicians under the informed consent statute,[93] the court relied on the underlying rationale of *Gray* to hold that "[i]t is the invasive nature of the surgical or operative procedure involving a surgical cut and the use of surgical instruments that gives rise to the need to inform the patient of risks prior to surgery."[94] Inferred by the majority's opinion is the belief that, apart from the statutorily created exceptions, the surgery requirement will remain as a bar to future patients' remedies under the informed consent statute.

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88. *See Morgan*, 704 A.2d at 620 (citing Gray v. Grunnagle, 223 A.2d 663, 668-69 (Pa. 1966)).

89. *See id.* at 620.

90. *See id.*

91. *See id.* at 620 n.6; *see also* Informed Consent, PA. STAT. ANN. tit. 40, § 1301.811-A (West Supp. 1998). Section 1301.811-A states, in part, as follows:

(a) Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representative prior to conducting the following procedures:

(1) Performing surgery, including the related administration of anesthesia.

(2) Administering radiation or chemotherapy.

(3) Administering a blood transfusion.

(4) Inserting a surgical device or appliance.

(5) Administering an experimental medication, using an experimental device or using an approved medication or device in an experimental manner.

Id.

92. *See Morgan*, 704 A.2d at 620 n.6.

93. *See id.*

94. *Id.* at 620 (citing Gray v. Grunnagle, 223 A.2d, 663, 668-69 (Pa. 1966)).

III. Analysis

A. Ambiguity of the Statute: Negligence v. Battery and the Differing Interpretations of Each

Pennsylvania's informed consent common law doctrine has traditionally framed nonconsensual treatment as a technical battery.[95] Eventually, this statute will replace the common law doctrine as a basis for informed consent actions. Consequently, it may be years before the court will hear arguments under the informed consent statute.[96] The Pennsylvania Supreme Court has yet to determine whether the statutory cause of action will continue under the battery theory or whether the rationale of the common law doctrine can be incorporated into the statute.

1. Negligence-Based Informed Consent—Pennsylvania is among "a shrinking minority of jurisdictions [that] persist in limiting informed consent actions to invasive procedures. In those jurisdictions, battery survives as the appropriate cause of action."[97] As recently as 1999, the New Jersey Supreme Court rejected the contention that failure to obtain a patient's informed consent was an action ground in battery.[98] Finding that a physician has a duty to obtain informed consent for non-invasive procedures, the court stated that a physician's failure to obtain consent is "better viewed as a breach of professional responsibility than as a nonconsensual

95. *See supra* Part II.

96. For example, nine years had elapsed between the time of Mrs. Morgan's injury and the court's decision. *See Morgan*, 704 A.2d at 617-8.

97. Matthies v. Mastromonaco, 733 A.2d 456, 460 (N.J. 1999) (citing Morgan v. MacPhail, 704 A.2d 617 (Pa. 1997)); *see also* Joan P. Dailey, Comment, *The Two Schools of Thought and Informed Consent Doctrines in Pennsylvania: A Model for Integration*, 98 DICK. L. REV. 713, 728 & n.101 (1994).

98. *See Matthies*, 733 A.2d at 460.

touching."[99] These sentiments are echoed by Justice Nigro in his dissenting opinion in *Morgan*.[100]

Not only does a negligence-based informed consent action comport with the notion of a physician's general duty to exercise reasonable care for the benefit of the patient;[101] a battery-based action is incongruous with the traditional elements of battery.[102] Under a battery theory of informed consent, the physician's failure to obtain consent lacks the malicious state of mind required to commit a battery.[103] The Pennsylvania Supreme Court's willingness to sustain a battery cause of action without the element of intent was tested in *Renk v. City of Pittsburgh*.[104] In *Renk*, the Court stated that it was conceivable for a jury to find a person liable for a battery under circumstances in which the person did not

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99. *See id.; see also* Shaw v. Kirschbaum, 653 A.2d 12, 16 (Pa. Super. Ct. 1994). "A prima facie case of medical malpractice based upon a negligent act or omission requires the plaintiff to establish:

(1) the existence of a duty owed by the physician/defendant to the plaintiff /patient;

(2) a breach of that duty;

(3) that the breach of duty was the proximate cause of, or a substantial factor in, bringing about the harm suffered by the plaintiff/patient; and

(4) damages suffered by the plaintiff/patient that were a direct result of the harm.

Id.

100. *See* Morgan v. MacPhail, 704 A.2d 617, 622 (Pa. 1997) (Nigro, J., dissenting) (summarizing decisions and concluding that "[o]ther states have decided that a doctor's duty to disclose the risks of medical treatment to the patient is an element of the duty of reasonable care. . . . I agree that a negligence theory provides a stronger basis for the informed consent doctrine than a battery theory.").

101. *See* Malloy v. Shanahan, 421 A.2d 803, 806 (Pa. Super. Ct. 1980) (Hoffman, J., dissenting). Judge Hoffman further states that "the physician's culpable conduct, the failure to inform, does not itself involve a 'touching' of the patient." *Id.*

102. Section 18 of the RESTATEMENT (SECOND) OF TORTS states:

(1) An actor is subject to liability to another for battery if

(a) he acts intending to cause a harmful or offensive contact with the person or the other or a third person, or an imminent apprehension of such a contact, and

(b) an offensive contact with the person of the other directly or indirectly results

(2) An act which is not done with the intention stated in Subsection (1)(a) does not make the actor liable to the other for mere offensive contact with the other person although the act involves an unreasonable risk of inflicting it and therefore, would be negligent or reckless if the risk threatened bodily harm.

RESTATEMENT (SECOND) OF TORTS § 18 (1977).

103. *See Malloy*, 421 A.2d at 806 (Hoffman, J., dissenting).

104. 641 A.2d 289 (Pa. 1994). *Renk* addressed whether the City of Pittsburgh must indemnify a police officer found liable for assault, battery, and false imprisonment. *See id.* at 291. At issue was whether a jury finding of liability imports willful misconduct on behalf of the officer, thereby eliminating the City's duty of indemnification. *See id.*

act with deliberate intent.[105] In dissent, three Justices maintained that battery is an intentional tort "which requires a conscious intent on the part of the actor to bring about the harm in question."[106]

In addition, under a battery theory, a physician may be liable for punitive damages for a non-consensual touching.[107] "It would be, however, improper to impose these sanctions upon the physician absent a finding of wilful [sic] misconduct."[108] Conversely, under a negligence theory, the patient must demonstrate that actual harm was incurred by the non-consensual touching.[109]

Finally, the Legislature's intent to use a negligence-based approach to informed consent is apparent in the statute's Declaration of Policy.[110] The General Assembly stated, "that it is the purpose of this article to streamline the legal process relating to medical *negligence* lawsuits . . . ."[111]

2. Battery-based Informed Consent—Although a negligence-based theory of informed consent has a logical appeal, the Pennsylvania Supreme Court has continued to embrace the notion that an informed consent cause of action is ground in battery.[112] If the court elects to maintain a battery standard, it must resolve the ambiguity surrounding the application of the statute. This ambiguity includes the extent in which the case law developed under the pre-statute common law is applied to the actions arising

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105. *See id.* at 293-94.

106. *Id.* at 294 (Montemuro, J., dissenting) (Justice Montemuro was joined by Chief Justice Nix and Justice Flaherty). The dissent continues to cite the RESTATEMENT (SECOND) OF TORTS § 18 as support. *See id.* Notably, Justice Flaherty, now Chief Justice of the Pennsylvania Supreme Court, joined the Majority opinion in *Morgan* rejecting a negligence-based informed consent doctrine. *See* Morgan v. MacPhail, 704 A.2d 617 (Pa. 1997).

107. *See Malloy*, 421 A.2d at 806 (Hoffman, J., dissenting). *See infra* note 151 (discussing the Pennsylvania Supreme Court decision to strike down provisions capping punitive damages as unconstitutional).

108. *Id.*

109. *See* Paula Walter, *The Doctrine of Informed Consent: To Inform or Not to Inform?*, ST. JOHN'S L. REV. 543, 552 (1997).

110. *See* PA. STAT. ANN. tit. 40, § 1301.801-A (West Supp. 1998).

111. *Id.* (emphasis added).

112. *See, e.g.,* Morgan v. MacPhail, 704 A.2d 617, 620 (Pa. 1997) (stating that the basis of a negligence standard "flies in the face of the traditional battery theory"). The Court's refusal to alter the basis of informed consent is found in the presumption that statutes never "make any innovation in the rules or principles of the common law or prior existing law beyond what is expressly declared in their provisions." *In re* Holton's Estate, 159 A.2d 883, 886 (Pa. 1960); *see also* Witthoeft v. Kiskaddon, 1999 WL 459851, at *3 (Pa. July 8, 1999) ("This court is hesitant to infer or imply a legislative intent where the impact of such a leap would constitute a drastic change in law.").

under the statute. The impracticality of wholesale abandonment of the principles of common law informed consent is obvious. Since the Legislature essentially codified, and then expanded, the judicially created doctrine of informed consent, the courts must apply concepts developed under the common law to undefined terms in the statute. For example, phrases such as "reasonably prudent patient" and "accepted medical standards of medical practice" necessitate an understanding and reliance on the common law definitions.[113]

Furthermore, the courts must refine the rationalization that it is the level of invasiveness, which determines a physician's duty to obtain informed consent.[114] Previously, the courts limited the level of touching required to sustain an informed consent action under the battery theory.[115] In *Wu v. Spence*,[116] the Superior Court held that the intravenous administration of therapeutic drugs was an insufficient level of touching when it was the medication that created the harm rather than the insertion of the needle.[117]

In contrast, the statute explicitly requires informed consent before the administration of radiation therapy, chemotherapy, and blood transfusion.[118] Under a "plain meaning" interpretation, these provisions address not only the insertion of a needle, but also include the effects of the medication and blood.[119] It would be absurd to interpret "administration" as limiting a physician's informed consent duty to simply advising patients of the risks and alternatives to the act of swallowing a pill, receiving an injection,

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113. *See generally* Laskowitz v. CIBA Vision Corp., 632 N.Y.S.2d 845 (N.Y. App. Div. 1995) (finding that the New York informed consent statute did not repeal the common law doctrine of informed consent as applied to health care providers not expressly included in the statute).

114. *See* Morgan v. McPhail, 672 A.2d 1359, 1364 (Pa. Super. Ct. 1996) (quoting Stover v. Ass'n of Thoracic & Cardiovascular Surgeons, 635 A.2d 1047, 1054 n.6 (Pa. Super. Ct. 1993)) ("[I]t would be less than candid if [the court] failed to 'admit to a degree of artificiality in creating a distinction which limits the touching required for actionable informed consent to be the surgical cut.' ").

115. *See, e.g., Morgan* 704 A.2d at 619-20 (Pa. 1997).

116. 605 A.2d 395 (Pa. Super. Ct. 1992).

117. *See id.* at 396-7; *see also* Karibjanian v. Thomas Jefferson Univ. Hosp., 717 F. Supp. 1081, 1084 (E.D. Pa. 1989); *Morgan*, 704 A.2d at 619-20 (citing *Wu* and *Karibjanian*).

118. *See* 40 PA. CONS. STAT. ANN. § 1301.811-A(a)(2)-(3) (West Supp. 1998).

119. The statute also requires a patient's informed consent for the administration of anesthesia and experimental medications. *See* PA. STAT. ANN. tit. 40, § 1301.811-A(a)(1), (5).

or inhaling anesthesia.[120] "Administration" can only be rationally interpreted as also encompassing the effect of the medication or anesthesia.[121] Essentially, the statute no longer creates a duty of informed consent based on the level of touching, but on what is administered. For example, the courts will be required to find a duty to obtain informed consent based on the type of medication rather than an actual procedure. Therefore, the level of touching under the pretext of a battery can be sustained through the patient's reaction to medicine or blood rather than the invasiveness of the procedure. The statute therefore directly conflicts with Pennsylvania's battery-based informed consent doctrine. Therein lies a latent ambiguity. The courts must resolve the ambiguity of whether, under the statute, the duty to obtain informed consent remains a cause of action grounded in battery. If a patient's reaction to medication can satisfy the level of touching necessary to demonstrate a battery, then the invasive nature of the surgical requirement must be re-examined.

Either the courts must find that the statute supplants the long held battery theory or rationalize that only certain medicines have the potential to "touch" the patient while others do not. Although the words of the statute may be patently unambiguous, in application, the statute has an intrinsically ambiguous result.[122]

3. Susceptibility of Differing Interpretations—In addition to an ambiguous outcome, the language of the statute is susceptible to differing interpretations.[123] The statute requires a physician to obtain the patient's informed consent for the following procedures: surgery and related anesthesia, radiation and chemotherapy, blood transfusions, insertion of surgical devices and appliances, experimental medications and devices, and medications and devices used in an experimental manner.[124] Without language limiting informed consent to these five enumerated scenarios contained, the statute can be reasonably interpreted to create a basis of physician

120. Under the rules of statutory construction it is presumed that the legislature did not intend an absurd result. *See* Presumptions in Ascertaining Legislative Intent, 1 PA. CONS. STAT. ANN. § 1922(1) (West 1995).

121. *Cf. id.*

122. *See In re* Kritz Estate, 127 A.2d 720, 723 (Pa. 1956) ("Rules of statutory construction are to be resorted to only when there is a patent or latent ambiguity: they [the rules] are not to be used to create doubt, but only to remove it.").

123. *See* Morgan v. MacPhail, 709 A.2d 917 620-23 (Pa. 1997) (Nigro, J., dissenting).

124. *See* 40 PA. CONS. STAT. ANN. § 1301.811-A (West Supp. 1998).

duty rather than a limitation. If the Legislature wished to limit physicians' duty to obtain informed consent, it would have inserted the appropriate limiting language in the statute.[125] Implicit in the codification and expansion of physicians' duty to obtain informed consent is the Legislature's obliteration of the surgical requirement.[126] " '[C]ourts sometimes have been slow to extend the effect of statutes modifying the common law beyond the direct operation of the words, it is obvious that a statute may indicate a change in the policy of the law, although it expresses that change only in the specific cases most likely to occur to the mind.' "[127]

This assertion is supported by Justice Nigro's dissent in *Morgan v. MacPhail*.[128] Dissenting from the majority's affirmation of the surgical requirement, Justice Nigro reiterated the Superior Court's contention that a surgical/non-surgical distinction is unfounded.[129] Furthermore, Justice Nigro argued that the Legislature has implicitly rejected such a distinction by requiring non-surgical procedures as part of a physician's statutory duty to obtain informed consent.[130] Justice Nigro's inference that the informed consent statute should be construed to eliminate the

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125. *See, e.g.*, PA. STAT. ANN. tit. 77, § 1208 (West 1992) (limiting the definition of occupational disease for worker's compensation); 23 PA. CONS. STAT. ANN. § 6353.3 (West Supp. 1998) (limiting information related to reports of student abuse or injury by a school employee); PA. STAT. ANN. tit. 40, § 282(a) (West Supp. 1998) (limiting the Insurance Commissioner's authority to temporarily certify or license agents and brokers); Pa. R.C.P. 1910.16-5(b) (limiting items to calculate monthly net income for support payments); PA. STAT. ANN. tit. 53, § 36909 (West 1998) (limiting specifications to be prepared for public building construction bids); *see also* PA. STAT. ANN. tit. 35, § 5641 (specifying the content of a consent for treatment of breast disease). *But cf.* Hoy v. Angelone, 720 A.2d 745, 748 (Pa. 1998) ("[I]t is reasonable to infer that the General Assembly's use of specific language . . . in numerous statutes reflects an intention to allow such a remedy only when expressly provided for.").

126. *See Morgan*, 704 A.2d at 622 (Nigro, J., dissenting).

127. *In re* United Sec. Trust Co., 184 A. 106, 111 (Pa. 1936) (quoting Gooch v. Oregon Short Line R. Co., 258 U.S. 22, 24 (1922)); *see also* Robert F. Williams, *Statutes as Sources of Law Beyond Their Terms in Common-Law Cases*, 50 GEO. WASH. L. REV. 554, 556 (1982) ("Courts can justifiably use statutes beyond their terms as sources of law for common-law decision making, because the policies underlying statutes often have significance beyond the test they inspired.").

128. *See Morgan*, 704 A.2d at 620-3 (Nigro, J., dissenting).

129. *See id.* at 622. In addition, Justice Nigro supported adoption of a negligence standard rather than maintaining the battery theory. *See id.*

130. *See id.* In a 42-word court order, the Pennsylvania Supreme Court, with Justice Nigro's dissenting, reiterated the *Morgan* opinion. *See* Milne v. Crossett, 709 A.2d 886 (Pa. 1998).

surgery requirement clearly demonstrates that the statute is susceptible to differing interpretations.[131]

Commenting on the statute, the Pennsylvania Supreme Court appears to have used the statutory construction doctrine of *expressio unis est exclusio alterius*[132] to interpret that the services listed in the informed consent statute necessarily exclude all others.[133] This maxim, however, should not be universally applied when it would defeat the manifest intent of the legislature.[134]

B. *Under the Rules of Statutory Construction, Pennsylvania Courts Must Ascertain and Effectuate the Legislative Intent of the Informed Consent Statute*

Under the rules of statutory construction,[135] a court cannot ignore the plain meaning of a statute when the words of the statute are unambiguous.[136] Furthermore, a court cannot disregard the plain meaning of an unambiguous statute in order to pursue its spirit.[137] In isolation, the words of the informed consent statute may appear unambiguous.[138] "Where, however, the statute is unclear or susceptible of differing interpretations,"[139] the courts must "ascertain and effectuate" the legislative intent underlying the statute.[140]

Given the latent ambiguity of the statute and the absence of language explicitly limiting a physician's duty to obtain a patient's informed consent, the courts must ascertain and effectuate the intent of the legislature *underlying* the statute.[141] Among the factors the court must consider are the occasion and necessity of the act, the object to be ascertained, the circumstances under which

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131. *See* City of Philadelphia v. Schaller, 25 A.2d 406, 409 (Pa. Super. Ct. 1942) (determining legislative intent is necessary where the statute has two or more meanings).

132. "A maxim of statutory interpretation meaning that the expression of one thing is the exclusion of another." BLACK'S LAW DICTIONARY 403 (6th ed. abr. 1991).

133. *See id.; see also Morgan*, 704 A.2d at 620 n.6.

134. *See* Knecht v. Medical Serv. Ass'n of Pa., 143 A.2d 820, 826 (Pa. Super. Ct. 1958).

135. *See* 1 PA. CONS. STAT. ANN. §§ 1921-1939 (West 1995).

136. *See* title 1 § 1921(b) (West 1995).

137. *See id.*

138. *See* PA. CONST. STAT. ANN. tit. 40, § 1301.811-A (West Supp. 1998).

139. Pennsylvania Fin. Responsibility Assigned Claims Plan v. English, 664 A.2d 84, 87 (Pa. 1995).

140. *See id.*; *see also* title 1 § 1921(a).

141. *See* title 1, § 1921(c) (West 1995).

it was enacted, the consequences of a particular interpretation, and other statutes affecting the same or similar persons.[142]

Once the intent of the General Assembly has been ascertained, it cannot be ignored and must be effectuated.[143] Without understanding the legislative intent and the policies behind the statute, Pennsylvania courts cannot properly apply the informed consent statute in future cases. A plain meaning application of the statute would produce the unreasonable result of excluding physicians from the duty of informing patients of the reasonable risks and alternatives to non-surgical procedures. When the plain meaning produces unreasonable results that are "at variance with the policy of the Legislation as a whole" the court should follow "that purpose, rather than the literal words."[144]

C. *The Objective of the Informed Consent Statute: Containing the Cost of Medical Malpractice*

The Act, focused on managing costs associated with malpractice insurance financing and lawsuits,[145] had two objectives: 1) Preventing the 254 percent malpractice premium surcharge through the CAT Fund; and 2) reforming the malpractice litigation process.[146] As a product of compromise between the PMS and PTLA, the tort reform contained a number of substantive and procedural changes to the malpractice litigation process.[147] Included in these changes were the placement of reasonable caps on punitive damages,[148] discouragement of frivolous lawsuits,[149]

142. *See id.* § 1921(c)(1)-(8); *English*, 664 A.2d at 87.

143. *See* Commonwealth v. Besch, 674 A.2d 655, 659 (Pa. 1996) (citations omitted).

144. *See* Swick v. School Dist. of Borough of Tarentum, 14 A.2d 898, 901 (Pa. Super. Ct. 1940) (quoting U.S. v. American Trucking Ass'n, 310 U.S. 534, 543 (1940) (internal quotations omitted)).

145. *See* Declaration of Policy, PA. STAT. ANN. tit. 40, § 1301.801-A (West Supp. 1998).

146. *See* S. 180-62, 2nd Legis. Sess. 2645 (Pa. 1996) (remarks of Senator Loeper); *see also* title 40, § 1301.801-A. The General Assembly declared that the purpose of the statute is to streamline the medical malpractice legal process to ensure prompt and efficient adjudication of claims. *See id.*

147. *See* McGaw, *supra* note 55.

148. *See* title 40, § 1301.812-A (capping punitive damage awards at 200 percent of compensatory damages).

149. *See id.* § 1301.813-A (allowing monetary sanctions against attorneys who bring frivolous medical malpractice suits); *see also id.* § 1301.821-A (requiring expert review of malpractice claims to prevent frivolous lawsuits).

and the creation of "a realistic standard for informed consent prior to conducting *any medical procedures*."[150]

Not only is inclusion of non-surgical procedures consistent with the legislative history, but obliterating the surgical requirement for informed consent is also consistent with the legislature's objective of reducing the costs of malpractice.[151] An expanded informed consent approach will encourage physicians to discuss the treatment risks and alternatives of non-surgical procedures. This approach of increasing physician communication is aligned with the concept that an informed patient is less likely to sue his/her physician.[152] The quality of physician-patient communications is associated with general patient dissatisfaction, which in turn is correlated to the litigation risk of the physician.[153] Therefore, increased communications between the physician and patient, via the physician's duty

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150. *See* S. 180-62, 2nd Legis. Sess. 2645 (Pa. 1996) (remarks of Senator Loeper) (emphasis added).

151. The efficacy of the General Assembly's reformation of malpractice litigation, however, may never come to bear. Within 53 days of the Act's passage the Pennsylvania Supreme Court struck down significant portions of the tort reform measures as unconstitutional. *See, e.g.,* Order of Supreme Court, Jan. 17, 1997, immediately suspending PA. STAT. ANN. tit. 40, § 1301.812-A(d),(e),(f) (allowing, *inter alia*, filing of *praecipe* to strike punitive damages and to bifurcate punitive damages from trial); *id.* § 1301.813-A (imposing a civil penalty against attorneys filing dilatory or frivolous motions, claims, and defenses); *id.* § 1301.821-A (requiring certification of malpractice complaint by an expert). The court invalidated these portions under authority of the Pennsylvania Constitution. *See* PA. CONST., art. V, § 10(c). *See generally In re* 42 PA.C.S.A. § 1703, 394 A.2d 444 (Pa. 1978) (interpreting the Pennsylvania Constitution as giving the state's Supreme Court exclusive jurisdiction to establish rules of procedure for state courts and the legislature is without power to control procedure). *See also* Dana Stuchell, Comment, *Constitutional Crisis in Pennsylvania: Pennsylvania Supreme Court v. Pennsylvania General Assembly.* 102 DICK. L. REV. 201 (1997).

152. *See* LaRae I. Huycke et al., *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 12 ANNALS OF INTERNAL MED. 792, 795 (1994) ("Miscommunication between patient and provider is clearly a major contributor to calls [by patients claiming to have suffered injury] received by attorneys."). Huycke's study identified five medical specialties most frequently (54%) named by plaintiff patients: obstetrics, family medicine, orthopedic surgery, emergency medicine, and general surgery. *See id.* at 794. The percentage of complaints alleging failure to inform or to educate by selected specialties is as follows: obstetrics (8.47%), family practice (8.56%), orthopedic surgery (21.57%), and emergency medicine (4.29%). *See id.* at tbl. 4. Huycke cautions, however, that although improved communication can decrease patient dissatisfaction, it is uncertain that it will reduce the risk of litigation. *See id.; cf.* Allen D. Spiegel et al., *Better Patient Communications Mean Lower Liability Exposure,* MANAGED CARE MAG., August 1997, at 119, 121 ("As a risk management tool, effective communication becomes a powerful way to reduce litigation and improve patient satisfaction.").

153. *See* Huycke et al., *supra* note 152, at 796.

to obtain informed consent, will also achieve the goal of reducing malpractice costs.

A study was performed measuring the relationship between obstetricians' prior malpractice experience and patients' satisfaction with their care.[154] Patient perceptions that obstetricians did not explain the labor and delivery process varied greatly between physicians with different malpractice experience.[155] Finding that physicians who have difficulty communicating with their patients are sued more frequently, the study concluded: "[A]ddressing patients' concerns may not only decrease the incidence of malpractice litigation, but is also desirable in and of itself."[156] Generalizing the obstetrician-patient relationship, a better-informed patient is less likely to sue. Therefore, expanding informed consent requirements to include non-surgical procedures could actually reduce malpractice claims with better treatment decisions and more satisfied patients.[157] "Patients who participate in and take some responsibility for their health decisions are less likely to blame their physicians if something goes wrong."[158]

In contrast, proponents of a strict interpretation of the statute may argue that limiting the patient's ability to bring an informed consent action is the most effective method to reduce malpractice litigation. This argument presupposes that informed consent actions continue under a battery-based theory rather than negligence.[159] Under a negligence theory, "[t]he critical consideration

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154. *See* Gerald B. Hickson, M.D. et al., *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction with Care,* 272 JAMA 1583 (1994).

155. *See id.* at 1587.

156. *Id.* Only 8.3% of patients perceived that they received inadequate explanation from obstetricians with less than average malpractice losses. *See id.* at 1586 tbl. 2. Obstetricians who either were frequently sued or paid greater than average malpractice claims, were perceived by 19.0% and 13.6% of their patients, respectively, as providing inadequate explanation of labor and delivery. *See id.*

157. See Peter H. Schuck, *Rethinking Informed Consent,* 103 YALE L. J. 899 (1994) for an excellent analysis of the informed consent doctrine. Schuck suggests that the benefits accruing to society from greater patient autonomy may outweigh the additional time required of physicians to explain the risks, benefits, and alternatives to treatment. *See id.* at 941. In addition, Schuck suggests that a "more robust informed consent [doctrine] is needed to counterbalance the growing bureaucratization and routinization of health care delivery." *Id.* Schuck recognizes limitations of informed consent and suggests that the efficacy of the doctrine be systematically analyzed. *See id.* at 959.

158. Flora J. Skelly, *The Payoff of Informed Consent,* 37 AM. MED. NEWS, August 1, 1994, at 11, (quoting Robin DiMatteo, Ph.D., Professor of Psychology at the University of California at Riverside).

159. *See supra* Part III.A.1 (Negligence-Based Informed Consent).

is not the invasiveness of the procedure, but the patient's need for information to make a reasonable decision about the appropriate course of medical treatment, whether invasive or noninvasive."[160] With negligence-based informed consent, the physician's duty to obtaining a patient's informed consent is analyzed in the context of a "duty of reasonable care."[161] Accordingly, the statute would provide physicians with a defense to informed consent cause of actions ground in negligence. The physician would be able to present evidence that consent was not reasonably possible,[162] the description, risks, and alternatives provided to the patient were adequate,[163] and the lack of information was of no consequence in the patient's decision.[164]

Using Pennsylvania law, the Third Circuit Court of Appeals recently remanded an action in which it was alleged that the physicians/defendants, *inter alia*, failed to provide information and make the appropriate treatment recommendation to the patient's family.[165] The appeal followed a jury finding that the physicians were negligent in advising the family about the patient's treatment.[166] The appellate court reversed the district court's decision to disallow the physicians from submitting the issue of the family's contributive negligence to the jury.[167] This case illustrates that, regardless of whether informed consent is negligence or battery based, actions pertaining to the level of information provided to patients may arise outside of the context of informed consent. Therefore, expanding physician duty to obtain informed consent by providing information concerning the risks and alternatives to

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160. Matthies v. Mastromonaco, 733 A.2d 4456, 464 (N.J. 1999). *But see* Shaw v. Kirschbaum, 653 A.2d 12, 15 (Pa. Super. Ct. 1994) (quoting Foflygen v. Zemel, 615 A.2d 1345, 1353 (Pa. Super. Ct. 1992)) ("Thus, we are compelled to analyze informed consent cases under a battery theory until and unless our Supreme Court decides to recognize an informed consent cause of action grounded in negligence.").

161. Morgan v. MacPhail, 704 A.2d 617, 622 (Pa. 1997) (Nigro, J., dissenting).

162. *See* PA. STAT. ANN. tit. 40, § 1301.811-A(a) (West Supp. 1998) (relieving physicians of the duty to obtain informed consent in an emergency).

163. *See id.* § 1301.88-A(b) (establishing a reasonably prudent patient standard and permitting evidence that the physician was acting within accepted standards of medical practice).

164. *See id.* § 1301.88-A(d) (placing the burden of proof on the patient to show that receiving information of the procedure, risks, and alternatives would have been a substantial factor in the patient's decision).

165. Alexander v. University of Pittsburgh Med. Ctr. Sys., Nos. 98-3402, 98-3501, 1999 WL 521753, at *2, *6 (3rd Cir. July 23, 1999).

166. *See id.* at *2.

167. *See id.*

treatment offers a defense to physicians and is consistent with the liability containment intent of the Act.

D. *The Informed Consent Statute in Pari Materia: Protecting Patients' Interests*

Under the rules of statutory construction, statutes in *pari materia* should be construed together as one.[168] "Statutes or parts of statutes are in *pari materia* when they relate to the same persons . . . or to the same class of persons."[169] Superficially, it would appear that the entire Health Care Services Malpractice Act, including its tort reform components and informed consent provision, was constructed to serve primarily physicians and attorneys. Moving to postpone consideration of the Act, Representative Vitali argued that the legislature should not simply "bow to the special interests . . . ."[170] In response, Representative Barley stated that the *people's interests* are being served by this legislation and it is reflected in their medical insurance rates and health care services.[171] Therefore, it can be concluded that the citizens of Pennsylvania, as patients and recipients of the physician's duty form a class of persons that the informed consent statute seeks to protect.[172] Hence, the statute should be construed with similar patient protections afforded by the legislature and its authorized agencies.[173]

Under the Health Care Facilities Act,[174] the Department of Health ("Department") is empowered to promulgate regula-

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168. *See* 1 PA. CONS. STAT. ANN. § 1932(b) (West 1995).

169. *Id.* § 1932(a).

170. *See* H. 180-62, 2nd Legis. Sess. 2453 (Pa. 1996). Representative Vitali argued that the Bill was drafted the previous weekend by the PMS and PTLA, and only available in its final form several hours before House debate. *See id.* Noting that the "bills turn on the specific language in them and the various nuances . . . ," Rep. Vitali stated that only a "handful" of trial lawyers and physicians are aware of the Bill's content. *See id.* at 2453-54.

171. *See id.* at 2454 (emphasis added). The motion to postpone subsequently failed by a vote of 27 to 168. *See id.*

172. *See generally* title 1 § 1932(b). Physicians may also be regarded as a class of persons protected by the statute. *See* discussion *supra* Part III, Section C (Objective of the Informed Consent Statute) (physician and patient interests are complementary rather than inapposite).

173. An agency's regulation "is valid and as binding as a statute upon a court" if it is adopted pursuant to a legislative grant of rule-making power. *See* Girard Sch. Dist. v. Pittenger, 392 A.2d 261, 262 (Pa. 1978) (citations omitted). It would follow that if a regulation has the force of a statute, then the regulation should be considered with other statutes affecting similar classes of persons under a *pari materia* analysis.

174. PA. STAT. ANN. tit. 35, § 448.101 (West 1993).

tions[175] necessary to, *inter alia*, coordinate the health care system to "enhance the public health and welfare by making the delivery system responsive and adequate to the needs of its citizens" and to ensure that "all citizens receive humane, courteous care."[176] In doing so, the Department has created a number of health care facility licensure regulations[177] designed to protect and inform patients of their care in settings such as nursing homes,[178] hospitals,[179] ambulatory surgery facilities,[180] and birth centers.[181] Furthermore, under the jurisdiction of the Department of Public Welfare, patient rights have been extended to include mental health procedures.[182]

The expansion of patient rights has not been limited to the licensure of health care facilities.[183] On June 17, 1998, the Pennsylvania Senate approved Act 68, mandating new patient and

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175. *See id.* § 448.803.

176. *Id.* § 448.102.

177. "To protect and promote the public health and welfare through . . . regulations setting minimum standards in the . . . operation of health care facilities. Such standards are intended by the legislature to . . . promote the health, safety, and adequate care of the patients . . . of such facilities." *See id.* § 448.801a.

178. *See* 28 PA. CODE § 201.29(g) (West 1999) (explaining that within a long-term care nursing facility, the physician shall inform the patient of his or her medical condition and allow the patient to participate in the planning of his or her medical treatment).

179. *See id.* § 119.23(b)(3) (explaining that in the hospital outpatient setting, the physician shall inform the patient of the medical problem, prognosis, and nature and purpose of contemplated treatment); *see also id.* § 103.22(b)(11) (requiring that in a hospital, a physician inform the patient of the medical consequences of the patient's refusal of any drugs, treatment, or procedure); *cf. id.* § 103.22(b)(9) (noting that in a hospital, informed consent is required only for procedures under section 1301.811-A of the Informed Consent Act.

180. *See id.* § 553.12(b)(8) (requiring that at an ambulatory surgery facility, a patient receive full information concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications); *cf. id.* § 553.12(b)(9) (noting that in an ambulatory surgery center, informed consent is required only for procedures under section 1301.811-A of the Informed Consent Act.

181. *See id.* § 501.46(b)(6) (requiring that at a birth center, a mother receive information of the nature, purpose, expected effects, and results of the medical treatment prior to signing an informed consent).

182. *See* 55 PA. CODE § 5100.54 art. 1, § 1(b) (noting that mental health patients have the right to be informed of diagnostic and treatment procedures, costs, and risks of treatment).

183. *See supra* text accompanying notes 174-81; *see also* Advance Directive For Health Care Legislative Findings and Intent, 20 PA. CONS. STAT. § 5402(a) (West Supp. 1999) ("The General Assembly finds that all competent adults have a qualified right to control decisions relating to their own medical care."); Resident Rights, 42 C.F.R. § 483.10(d)(2) (1999) (stating that nursing home residents have a "right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being").

physician protections under managed care plans.[184] Recognizing substantial elements of informed consent, managed care plans are prohibited from restricting discussions between health care providers and patients regarding the nature, risks, and alternatives of medically necessary treatment.[185]

Therefore, the informed consent statute, when read in conjunction with provider regulations and laws, should be construed as protecting similar patient interests.[186] It is apparent that the Legislature has intended to ensure that patients are informed of the care that they are to receive.

E. Liberally Interpreting Informed Consent: The Public Interest in Expanding Physician Duty

The derived legislative intent of the statute can be summarized as serving two purposes: 1) Reducing the cost of medical malpractice; and 2) Protecting the interests of patients.[187] To effectuate this intent, courts must choose whether to apply the informed consent statute in either a strict or liberal manner.[188] Provided that the Act is explicitly insurance related,[189] the informed consent statute, passed under the Act, should receive the same liberal interpretation that courts have applied to other insurance laws.[190] In doing so, the court should construe the statute in favor of the public interest.[191]

In *Miller v. United States Fidelity and Guaranty Co.*, the Superior Court considered whether the legislative intent of

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184. *See* The Insurance Company Law of 1921 Amendments of 1998, art. XXI, sec. 2113, § 991.2113(a)(2), 1998 Pa. Laws 68 ("Quality Health Care Accountability Act").

185. *See id.*

186. *See* Dept. of Highways v. Pennsylvania Pub. Util. Comm'n, 182 A.2d 267, 272 (Pa. Super. 1962) ("Statutes should be construed . . . so as to avoid any conflict between various agencies . . . .").

187. *See supra* Part III.C-D.

188. *See* 1 PA. CONS. STAT. ANN. § 1928(b)-(c) (West 1995) (providing that penal, retroactive, taxation, eminent domain, jurisdiction statutes, and provisions prior to 1937 that are in derogation of the common law are to be strictly construed, while all other provisions of a statute shall be liberally construed to reach their objectives and promote justice).

189. The statute was promulgated as part of a reform package to maintain the CAT Fund and contain physician malpractice premiums. *See supra* Part II.B. In addition, the entire statute falls under the jurisdiction of the Department of Insurance. *See* Health Care Services Malpractice Act, PA. CONS. STAT. ANN. tit. 40, §§ 1301.101-.1006 (West 1995).

190. *See* Miller v. U.S. Fidelity and Guaranty Co., 450 A.2d 91 (Pa. Super. Ct. 1982); McClung v. Breneman, 700 A.2d 495 (Pa. Super. Ct. 1997).

191. *See McClung*, 700 A.2d at 497.

Pennsylvania's Non-Fault Motor Vehicle Insurance Act[192] allowed the recovery of "work loss" benefits by the decedent's estate when the administrator of the estate was not a "survivor" as defined by the statute.[193] Under Pennsylvania's rules of statutory construction, penal, retroactive, taxation, eminent domain, and jurisdiction statutes are to be strictly construed.[194] The court stated that because insurance statutes did not require strict interpretation, these statutes are to be liberally construed to effect their purpose.[195] Adopting the *Miller* court's liberal interpretation of insurance statutes, the Superior Court, in 1997, examined another motor vehicle insurance statute.[196] Holding that uninsured motorists are precluded from recovering medical expenses from third party tortfeasors,[197] the court stated that its duty is to "give effect to the entire statute and to favor the public interest as against any private interest."[198]

With *In re Fiori*,[199] the Pennsylvania Supreme Court provided assistance in identifying the public interest at stake with informed consent. The court considered whether a close relative of a patient in a persistent vegetative state, in the absence of an advance directive, could remove the patient's life sustaining treatment.[200] Holding that the relative, with the consent of two physicians, could remove life-sustaining treatment, the court explicitly stated that its ruling applied only to the unique fact pattern of the case.[201] The court's analysis, however, rather than its holding, is applicable to interpreting the public interest served by informed consent.

Examining the common law right of self-determination,[202] the

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192. PA. STAT. ANN. tit. 40, § 1009.103 (West 1992) (repealed 1984).

193. *See Miller*, 450 A.2d at 93.

194. *See* 1 PA. CONS. STAT. ANN. § 1928(b)-(c) (West 1995).

195. *See Miller*, 450 A.2d at 97 (citing Mattia v. Employers Mut. Cos., 440 A.2d 616 (Pa. Super. 1982)); *see also* 1 PA. CONS. STAT. ANN. § 1928(b)-(c) (West Supp. 1998).

196. *See McClung*, 700 A.2d at 495-97 (examining the Motor Vehicle Financial Responsibility Law, 75 PA. CONS. STAT. ANN. §§ 1701-1799 (West 1996)).

197. *See id.* at 497.

198. *Id.* (citing 1 PA. CONS. STAT. ANN. § 1922(5) (West 1995)).

199. 673 A.2d 905 (Pa. 1996).

200. *See id.* at 908.

201. *See id.* at 913.

202. The *Fiori* court "eschewed an analysis based on constitutional principles." *Id.* at 909. *But cf.* Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 278 (1990) ("The Fourteenth Amendment provides that no State shall 'deprive any person of life, liberty, or property, without due process of law.' The principle that a competent person has a

court cited the U.S. Supreme Court's recognition that "[n]o right is held more sacred, or is more carefully guarded, . . . than the right of every individual to the possession and control of his person . . . ."[203] Attributing the development of the informed consent doctrine to the right to be free from bodily invasion,[204] the court stated that in the absence of an emergency, " 'medical treatment may not be imposed without the patient's informed consent.' "[205]

Tracing a corollary to this doctrine, the court found that it is the patient's right to withdraw consent and to refuse treatment once it has begun.[206] Given the importance of a patient's right to self-determination in regard to continuing life-sustaining treatment, it is not without basis that the physician's duty to obtain a patient's informed consent can be expanded to include all life saving treatments regardless of their invasive nature.

F. The Limits of a Physician's Duty to Obtain Informed Consent

Drawing upon legislative intent, coupled with a liberal interpretation favoring the public interest, the duty of informed consent should not be limited to examples contained in the statute. With the increasing number of non-surgical treatments and

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constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."). It follows that for persons to exercise their Constitutional right to refuse medical treatment, they must first be informed of the risks and alternatives of the proposed treatment. If the corollary to refusing treatment is consenting to treatment, then persons arguably have a Constitutionally derived right to be afforded the consideration of informed consent. To exercise this right, physicians must assume the duty to obtain the patient's informed consent before treatment. Previously, the U.S. Supreme Court has "balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Id.* (citing Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905)). The question of whether the Commonwealth's interest in lowering medical malpractice premiums outweighs patients' right to give their informed consent prior to medical procedures not enumerated in the statute is saved for another day.

203. *Id.* at 909-10 (quoting Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891)).

204. *See id.* at 910 (citing Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (1914) (Cardozo, J.). Notably, Judge Hoffman similarly quoted *Schloendorff* ("Every human being of adult years and sound mind has a right to determine what shall be done with his body." *See* Malloy v. Shanahan, 421 A.2d 803, 805-6 (Pa. Super. Ct. 1980) (Hoffman, J. dissenting) (quoting *Schloendorff*, 105 N.E. at 93)). Hoffman reasoned that the informed consent doctrine should be grounded on negligence rather than on battery. *See Malloy*, 421 A.2d at 805.

205. *In re* Fiori, 673 A.2d at 910 (quoting Moore v. Raechle A.2d 1003 (Pa. 1992)).

206. *See id.*

procedures being used in modern medicine,[207] the time has come to expand physicians' duty to obtain informed consent. It is ironic that the public interest in a patient's right to self-determination, as enunciated by the Pennsylvania Supreme Court, is not protected under the informed consent statute.

Courts should not construe the informed consent statute as a bar against patients' receiving information from their physicians in order to make an informed decision concerning non-surgical procedures. While the purpose of requiring informed consent is to increase patient autonomy in medical decision-making, consent forms are symbolized as somewhat of a medical Miranda warning.[208] To change physician perceptions, informed consent should be re-cast as recognition of "the physician's responsibility for the well-being of the patient."[209] The medical profession has recognized that "the patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.[210]

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207. *See, e.g., Hospital to Use New Technique in Brain Surgery,* HARRISBURG PATRIOT, Nov. 30, 1998, at B8 (using a low-density cobalt beam to perform brain surgery without an incision); *Perspectives on the Marketplace: Assessing Medical Innovations: How Health Plans Pick What Technology to Cover*, MED. & HEALTH, May 26, 1997, *available in* 1997 WL 8689135 (detecting ulcer causing bacteria with an oral diagnostic solution rather than a stomach biopsy performed in surgery center); *FDA Approves Yet Another Option: Microwave Therapy*, REPORT ON MED. GUIDELINES & OUTCOMES RES., May 16, 1996, *available in* 1996 WL 11666389 (using microwaves as an alternative to drugs and surgery for treating symptoms of benign prostatic hyperplasia); *Surgery Adds to Arsenal Against Gallstones*, HOSP. & HEALTH NETWORKS, Apr. 5, 1990, *available in* 1990 WL 2630423 (noting non-invasive lithotripsy under review for potentially destroying healthy tissue).

208. *See* Alan Meisel & Mark Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156 ARCHIVES OF INTERNAL MED. 2521, 2522 (1996). Concerns have been expressed that expanding a physician's duty to obtain informed consent would excessively strain the health care delivery system with unnecessary bureaucracy. *See* Gouse v. Cassel, 615 A.2d 331, 334 (Pa. 1992). Discussing the reasonably prudent patient standard of informed consent, the Pennsylvania Supreme Court stated that it would not be "unduly burdensome" to require physicians to communicate "material facts, risks, complications, and alternatives to surgery" to their patients. *See id.* Under this standard, only information considered material by a reasonably prudent patient is necessary. *See id.* Therefore, a balance is struck between the physician's disclosure of every possible risk and the patient's right to medical self-determination. *See id.*

209. Meisel & Kuczewski, *supra* note 208, at 2522. The authors give this closing advice to physicians: "Do not make [patients] think that you do not have time for them. Because if you do, regardless of how much information they are given, they are going to be angry, and another name for an angry patient is plaintiff." *Id.* at 2526.

210. Patient Right to Know: Hearings on H.R. 2976 Before the Subcomm. on Health of the House Comm. on Ways and Means, 104 Cong. (1996) (statement of John C. Nelson, M.D., Board of Trustees of the American Medical Association and Deputy Director of the

An expansive interpretation of the informed consent statute would assign physicians the duty to provide patients with information about non-surgical procedures, risks, and alternatives.[211] This concept of duty would amount "to no more than 'the sum total of those considerations of policy which led the law to say that the particular plaintiff is entitled to protection' from the harm suffered."[212] Pennsylvania courts, applying this duty concept "must be guided by our recently decided cases on the same subject matter and by our best information as to legislative intent as well as by our sense of history, morals and justice."[213] When the policies of misguided malpractice containment legislation "pale in comparison to the harm at issue," the lack of a statutory duty to obtain informed consent should not bar a patient from maintaining a cause of action against a physician.[214]

IV. Conclusion

The codification of Pennsylvania's informed consent doctrine has implicitly effaced the invasive surgical requirement. Although unambiguous on the surface, the informed consent statute is latently ambiguous in whether the battery-based common law can continue to rationalize the invasiveness of the surgical requirement. Without a battery requirement, the level of bodily invasion remains to be determined by the courts. In view of this ambiguity, courts should examine the statute's underlying legislative intent.

A liberal application of the statute will fulfill the intent of the legislature. Expanding physician duties under the statute to obtain patients' informed consent for non-surgical procedures will protect

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Utah Department of Health). Dr. Nelson, speaking in opposition to HMO gag clauses, stated that physicians have an ethical and legal duty under the Fundamental Elements of the Patient-Physician Relation of the American Medical Association's (AMA) Code of Medical Ethics to ensure that patients are fully informed of treatment options. *See id.* The AMA Code of Medical Ethics states, "the patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." Matthies v. Mastromonaco, 733 A.2d 456, 463 (N.J. 1999) (quoting American Medical Ass'n, Code of Medical Ethics: Current Opinions with Annotations, Opinion 8.08 (1981)).

211. *See* Morgan v. MacPhail, 704 A.2d 617, 622 (Pa. 1997) (Nigro, J., dissenting).

212. Gardner v. Consolidated Rail Corp., 573 A.2d 1016, 1020 (Pa. 1990) (quoting Sinn v. Burd, 404 A.2d 672, 681 (Pa. 1979)). The late Dean Prosser has stated that "social ideas as to where the loss should fall" is among factors in determining the existence of a duty. *See* Dean Prosser, *Palsgraf Revisited*, 52 MICH. L. REV. 1, 14-15 (1953) (quoted in *Sinn*, 404 A.2d at 681).

213. *Gardner*, 573 A.2d at 1020-21.

214. *See* DiMarco v. Lynch Homes, 583 A.2d 422, 425 n.1 (Pa. 1990).

patient interests. Furthermore, increasing communication between physicians and patients not only improves patient satisfaction, but it also reduces litigation by apprising patients of the risks and alternatives to treatment. With non-invasive medical treatments and focus on patient autonomy continuing to increase, it is time to interpret reasonably the informed consent statute to include any patient treatment, regardless of its nature, which involves the risk of serious injury.

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